Rappahannock Emergency Medical Services Council, Inc.

AGENCY: _____

SOURCE TESTING REQUEST

CONFIDENTIAL

Part I: Patient Information			
Name (Last, First, MI):			
Sex:	Age:	DOB:	Social Security#:
Part II: Exposure Information			
A. Exposed to: Blood☐ Saliva☐ Tears☐ Emesis☐ Feces☐ Sputum☐ Urine☐ Other(specify)☐			
B. Route of exposure: Percutaneous☐ Mucous Membranes☐ Open Skin(cut, etc.)☐ Dermatitis☐ Other(specify)☐			
C. Area exposed: Hand/Finger☐ Nose/Mouth☐ Face☐ Eye☐ Arm☐ Leg☐ Torso☐ Other(specify)☐			
D. Visible blood on device or in fluid? Yes☐ No☐			
E. Amount of blood/body fluid exposed to: Minor☐ Moderate☐ Major☐			
F. How deep was the injury? Superficial(scratch)☐ 0.25cm☐ 0.5cm☐ Deep☐			
G. Type of device: IV /Hollow-bore needle☐ Butterfly☐ Scalpel☐ Lancet☐ Knife blade☐ Other(specify) ☐ N/A☐			
H. Was the needle in an artery or vein? Yes☐ No☐ N/A☐			
I. PPE used: Uniform☐ Gown☐ Eye Protection☐ Firefighting protective equipment☐ Patient Care Gloves☐ Mask☐ Leather/Extrication Gloves☐ Other(specify) ☐			
J. Procedure being performed: Hemorrhage Control☐ IV/Medication Administration☐ Sharps Disposal☐ Finger Stick Airway Management☐ Decontamination☐ Passing Instrument☐ Other(specify)☐			
Part III: Employee Information			
Name (Last, First, MI):			Rank:
Exposure date:		Exposure time:	
Receiving facility of patient:		Patient's receiving facility room #:	
Receiving nurse/physician:		Nurse/physician's contact #:	
Part IV: Infection Control Officer Requesting Source Testing			
Inf. control officer (PRINT):		Inf. control officer (SIGNATURE):	
Date notified of exposure:		Time notified of exposure:	
Date request was faxed to facility:		Time request was faxed to facility:	
Part V: Facility Receiving Request (TO BE COMPLETED BY CHARGE NURSE/PHYSICIAN)			
Name Of Facility:		Contact #:	Fax #:
File #:	Patient history #:	Unit/Room # patient admitted to:	
Date/Time request was received:		Date/Time request was completed:	
Charge Nurse/Physician who received and completed request (PRINT):			
Charge Nurse/Physician who received and completed request (SIGNATURE):			

REMINDER TO INFECTION CONTROL OFFICER:

FAX OR DELIVER A COPY OF THIS REQUEST TO THE APPROPRIATE HOSPITAL DEPT:

- **MARY WASHINGTON HOSPITAL - TAMI JEFFRIES OF ASSOCIATE WELLNESS**
  PHONE: 540-741-3618; FAX: 540-741-3614;
- **CULPEPER REGIONAL HOSPITAL - MARIE THOMPSON, INFECTION CONTROL**
  PHONE: 540-829-4385; FAX: 540-829-5719;
- **FAUQUIER HOSPITAL - DOROTHY SEIBERT, INFECTION CONTROL PRACTIONER**
  PHONE: 540-316-4735; FAX: 540-316-4731

AS SOON AS POSSIBLE.

Updated 11/7/08